NOTE: Complete both sides of this page for ALL annual reports.

Fiscal Year Ending **June 30, 2000**

State of California
Department of Industrial Relations
Self Insurance Plans
2265 Watt Avenue, Suite 1
Sacramento, CA 95825
Web site http://sip.dir.ca.gov
E-mail: sip@dir.ca.gov

PUBLIC SELF INSURER'S ANNUAL REPORT FOR JOINT POWERS AUTHORITY AND MEMBERS

I. GENERAL

1. JPA CERTIFICATE NUMBER: ☐-☐☐☐☐-☐☐-☐☐☐

☐ Active ☐ Revoked

2. PERIOD OF REPORT:

☐ Full Year ☐ Interim Report for the Period of:

☐☐☐☐☐☐ (Month Day Year) to ☐☐☐☐☐☐ (Month Day Year)

3. NAME OF MASTER CERTIFICATE HOLDER (JPA):

_____

Federal Tax Identification No.: _____

_____

Address of Main Headquarters

_____

CITY STATE ZIP + 4

4. TYPES OF PUBLIC AGENCIES IN THIS JPA:

☐ CITY/COUNTY ☐ POLICE/FIRE ☐ TRANSIT
☐ SCHOOL ☐ HOSPITAL ☐ OTHER

5. During the period of this report, has there been any of the following with respect to the JPA or its member agencies? (If yes, explain on reverse side of this page.)

A merger or unification?	☐ Yes	☐ No
Change in name or identity?	☐ Yes	☐ No
Any addition to Self Insurance Program?	☐ Yes	☐ No

6. Are there any JPA or member agency employees NOT included in your JPA's Workers' Compensation Self Insurance Program?

☐ Yes ☐ No

If yes, what employees are not included? _____

_____

Are these employees covered by an insurance policy?	☐ Yes	☐ No
Are these employees covered by another self insurance cert. or JPA?	☐ Yes	☐ No

7. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESSED?

NAME/TITLE: _____

AGENCY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP + 4: _____

TELEPHONE: ( ) _____ FACSIMILE (FAX): ( ) _____

E-MAIL ADDRESS: _____

8. CERTIFICATION BY JOINT POWERS AUTHORITY OFFICIAL:

I declare under the penalty of perjury that I have examined this Self Insurer's Annual Report and to the best of my knowledge and belief it is true, correct and complete.

Signature (Original Only): _____ Date: _____

Typed Name: _____

Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4: _____

Telephone: ( ) _____ Facsimile (FAX): ( ) _____

ANNUAL REPORT IS DUE OCTOBER 1, 2000

JPA CERTIFICATE NUMBER: ☐-☐☐☐☐-☐☐-☐☐☐

5. (Continued) _____

9. List the full legal names of each separate subsidiary or affiliate agency whose liabilities are being reported under this annual report, the certificate number of each such member, and its federal tax identification number.

Also include the Employment and Wages paid for the applicable calendar year. The number of employees should include all employees for which a W-2 tax form was issued. The salary information reported should be consistent with the figures reported on the employers EDD Form DE-6 (enter total of figures reported on the DE-6 for all four quarters).

	Affilliate Certificate No.	Full Legal Name	Member Federal Tax ID No.	No. of Employees in 1999-2000 for this Member	Wages/Salaries Paid in 1999-2000 by this Member
1.					$
2.					$
3.					$
4.					$
5.					$
6.					$
7.					$
8.					$
9.					$
10.					$
11.					$
12.					$
13.					$
14.					$
15.					$
16.					$
17.					$
18.					$
19.					$
20.					$
21.					$
22.					$
23.					$
24.					$
25.					$
26.					$
27.					$
28.					$
29.					$
30.					$

NOTE 1: Add additional page to list additional numbers, if necessary.

NOTE 2: If more than one claims administrator is used, then liabilities must be reported for each claims adjusting location using a Page 3, Liabilities by Reporting Location, and a Page 2, Consolidated Liabilities, for all liabilities of the JPA.

II. CONSOLIDATED JPA LIABILITIES

Certificate Number: ☐-☐☐☐☐-☐☐-☐☐☐

Name of Joint Power Authority: _____

Type of Report:

☐ **Original** Report (Due October 1 each year)

☐ **Amended** Report:

From Date: Month Day Year To Date: Month Day Year

A. CASES AND BENEFITS (to nearest dollar)

		Incurred Liability		Paid to Date		Future Liability	
	Number	$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1. Cases open as of 6/30/2000 reported prior to FY 1995-96							
2. Open & Closed Cases:							
a. FY 1995-96 Total cases reported							
FY 1995-96 Cases open							
b. FY 1996-97 Total cases reported							
FY 1996-97 Cases open							
c. FY 1997-98 Total cases reported							
FY 1997-98 Cases open							
d. FY 1998-99 Total cases reported							
FY 1998-99 Cases open							
e. FY 1999-2000 Total cases reported							
FY 1999-2000 Cases open							

	$ Indemnity	$ Medical
SUBTOTAL		
TOTAL		

3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)

$ Indemnity	$ Medical

4. Total Benefits paid during FY 1999-2000 (include all case expenditures): . . . . . _____

5. Number of MEDICAL-ONLY cases reported in FY 1999-2000: . . . . . _____

6. Number of INDEMNITY cases reported in FY 1999-2000: . . . . . _____

7. TOTAL of 5 and 6 (also enter in 2e above): . . . . . _____

8. TOTAL number of open indemnity cases (all years): . . . . . _____

9. Number of Fatality cases reported in FY 1999-2000: . . . . . _____

10. (a) Number of FY 1999-2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 1999-2000: . . . . _____

(b) Number of non-FY 1999-2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 1999-2000: . . . . _____

B. TOTAL EMPLOYMENT AND WAGES PAID IN FISCAL YEAR 1999-2000 FOR THIS JPA:*

(a) NUMBER OF EMPLOYEES _____
(Total number of employees for all members of this JPA)

(b) TOTAL WAGES AND SALARIES PAID* $ _____
(Total wages paid by all JPA members)

NOTE: Figure totals should agree with total of columns of entries on reverse side of Page 1 for all individual JPA affiliate members in the JPA.

IIA. ADMINISTRATOR

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) AT THE TIME OF PREPARING THIS REPORT.

1. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

2. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

3. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

4. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** ____ **Zip+4** _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THIS REPORTING PERIOD? ☐ **YES** ☐ **NO** **IF YES, DATE OF CHANGE:** ☐☐☐☐☐☐ (Month Day Year)

TYPE OF CHANGE: ☐ **Change in Administrative Agency**

☐ **Change to or from Self Administration**

C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINISITRATIVE AGENCY(IES):

Name _____

Agency Name _____

Address _____

City _____ **State** ____ **Zip+4** _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this consolidated report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

_____ _____

Original Signature of Administrator (Person) **Date**

_____ _____

Typed Name of Administrator **Name of Administrative Agency or Employer**

_____ _____

Title **Street Address**

_____

City **State** **Zip+4**

Phone No. of Administrator ( ) _____ **FAX No. ( )** _____

area code **area code**

E-mail Address of Administrator _____

NOTE: **Claims Administrator**
*Complete this page for **each adjusting** location where there are at least two adjusting locations.*

III. LIABILITIES BY REPORTING LOCATION

Reporting Location Nos.: ☐-☐☐☐☐-☐☐-☐☐☐

Name/Identification of Location: _____
OR
Name of Affiliate/Subsidiary Certificate Holder: _____

Type of Report:

☐ **Original** Report (Due October 1 each year)

☐ **Amended** Report:
From Date: ☐☐ Month ☐☐ Day ☐☐ Year To Date: ☐☐ Month ☐☐ Day ☐☐ Year

A. CASES AND BENEFITS (to nearest dollar)

		Incurred Liability		Paid to Date		Future Liability	
	Number	$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1. Cases open as of 6/30/2000 reported prior to FY 1995-96							
2. Open & Closed Cases:							
a. FY 1995-96 Total cases reported							
FY 1995-96 Cases open							
b. FY 1996-97 Total cases reported							
FY 1996-97 Cases open							
c. FY 1997-98 Total cases reported							
FY 1997-98 Cases open							
d. FY 1998-99 Total cases reported							
FY 1998-99 Cases open							
e. FY 1999-2000 Total cases reported							
FY 1999-2000 Cases open							

	$ Indemnity	$ Medical
SUBTOTAL		
3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical) **TOTAL**		

$ Indemnity	$ Medical

4. Total Benefits paid during FY 1999-2000 (include all case expenditures): . . . . . _____

5. Number of MEDICAL-ONLY cases reported in FY 1999-2000: . . . . . _____

6. Number of INDEMNITY cases reported in FY 1999-2000: . . . . . _____

7. TOTAL of 5 and 6 (also enter in 2e above): . . . . . _____

8. TOTAL number of open indemnity cases (all years): . . . . . _____

9. Number of Fatality cases reported in FY 1999-2000: . . . . . _____

10. (a) Number of FY 1999-2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 1999-2000: . . . . _____

(b) Number of non-FY 1999-2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 1999-2000: . . . . _____

IIIA. ADMINISTRATOR

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) AT THE TIME OF PREPARING THIS REPORT.

1. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** _____ **Zip+4** _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ **YES** ☐ **NO** **IF YES, DATE OF CHANGE:** ☐☐☐☐☐☐ Month Day Year

TYPE OF CHANGE: ☐ **Change in Administrative Agency**

☐ **Change to or from Self Administration**

C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINISITRATIVE AGENCY(IES):

Name _____

Agency Name _____

Address _____

City _____ **State** _____ **Zip+4** _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this consolidated report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

_____ _____

Original Signature of Administrator (Person) **Date**

_____ _____

Typed Name of Administrator **Name of Administrative Agency or Employer**

_____ _____

Title **Street Address**

_____

City **State** **Zip+4**

Phone No. of Administrator ( ) _____ **FAX No. ( )** _____

area code **area code**

E-mail Address of Administrator _____

IV. RECORDS STORAGE

1. Are claims records stored at any location other than with the current administrator?

☐ **Yes** ☐ **No** **If yes, Where?** _____

A. Agency Name _____
Address _____
City _____ **State** ____ **Zip+4** _____
Phone (____) _____

B. Agency Name _____
Address _____
City _____ **State** ____ **Zip+4** _____
Phone (____) _____

C. Agency Name _____
Address _____
City _____ **State** ____ **Zip+4** _____
Phone (____) _____

D. Agency Name _____
Address _____
City _____ **State** ____ **Zip+4** _____
Phone (____) _____

V. INSURANCE COVERAGE

1. Are any of your workers' compensation liabilities in California during the reporting period covered by a standard workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Insurance Company: _____
Policy Number: _____ **Policy Issue Date:** _____

2. Name of Insurance Company: _____
Policy Number: _____ **Policy Issue Date:** _____

2. Are any of your workers' compensation liabilities in California during the reporting period covered by a specific excess workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

2. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

3. Do you carry an aggregate (stop loss) workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

2. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

VI. OPEN INDEMNITY CLAIMS

A. List of *ALL* Open Indemnity Claims by reporting location and by year reported and with claims in alphabetical order is attached immediately following page 6 of this report.
(You may use the form attached or a computer-prepared printout organized in the same format.)

VII. FUNDING OF JPA LIABILITIES

1. Which of the following best describes the method the JPA uses to fund workers' compensation claim liabilities?

- ☐ Actuary Basis
- ☐ Cash Flow Basis
- ☐ Budgeted Amount
- ☐ Percentage Above Last Year's Losses
- ☐ Each Member Funds Their Own Claim Liability
- ☐ Other: _____

2. Has the JPA set aside aggregate funding for incurred but not reported claims for FY 1999-2000?

☐ Yes ☐ No If yes, what amount? $ _____

3. Did the JPA conduct an actuary study of the JPA's funding of workers' compensation liabilities by an outside, independent actuary during the period July 1, 1999 to June 30, 2000?

☐ Yes ☐ No

What was the date of the last actuary study? _____

How often does the JPA have an actuary study done? _____

4. Did the JPA have a claims audit performed by an outside, independent claims auditor during the period July 1, 1999 to June 30, 2000?

☐ Yes ☐ No

What was the date of the last outside, independent claims audit? _____

How often does the JPA have an outside, independent claims audit done? _____

5. Did the JPA have an annual financial audit conducted by a certified public accountant during the period July 1, 1999 to June 30, 2000?

☐ Yes ☐ No

What was the date of the last financial audit? _____

How often are such outside financial audits conducted? _____

6. Who established the level of funding for the JPA's workers' compensation claims?

- ☐ JPA Management
- ☐ Third Party Administrator
- ☐ Insurance Broker
- ☐ Consultant
- ☐ Other: _____

7. Can any member of the JPA leave and take their claims liability and equity with them?

Liability: ☐ Yes ☐ No

Equity: ☐ Yes ☐ No

8. Does the JPA have authority under its governing document (such as contract or by-laws, etc.) to assess JPA members for additional funding, if necessary?

☐ Yes ☐ No

Page _____ of _____ Pages

LIST OF OPEN INDEMNITY CASES

AS OF _____
(Date)

Reporting Location No.: _____

Certificate Number: _____

All Cases on this Page are

For the Year _____

NAME OF MASTER CERTIFICATE HOLDER: _____

Name of Insured or Deceased (Last) (First Initial)	Date of Injury	Labor Code Section 4850 Salary	Description of Injury	Paid to Date		Estimated Future Liability	
				$ Indemnity	$ Medical	$ Indemnity	$ Medical
(List Alphabetically within year)							